



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
3255 W PIONEER PKWY
ARLINGTON TX 76103

Respondent Name

New Hampshire Insurance Co

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-2378-02

MFDR Date Received

March 16, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...a supplemental payment is due"

Amount in Dispute: \$26.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Notice of medical fee dispute was acknowledged however, no response was received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2008	Outpatient Hospital Services	\$26.83	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 13, 2012

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- W1 – Workers Compensation State Fee Schedule Adjustment.

Explanation of benefits dated April 12, 2012

- W1 – Workers Compensation State Fee Schedule Adjustment

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1)(B) states: "A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury or liability." The date of the final benefit review conference is December 12, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on March 16, 2012. This date is later than 60 days after the final decision of the benefit review conference. The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

_____	_____	May 16, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.